

TREATING PANEL OF PHYSICIANS AND CHIROPRACTORS APPLICATION

Physician or Chiropractor

First Name: _____ Last Name: _____ Middle Init: _____ License Type: _____
 NV License Nbr: _____ Expire Date: _____
 Personal Email: _____
 Work Email: _____

Specialties / Area(s) of Practice - Choose all that apply

Addiction Medicine	Dermatology	Internal Medicine	Orthopedic
Anesthesiology	Endocrinology	Maxillofacial/Oral Surgery	Pain Management
Cardiology	Family/General Practice	Neurology	Physiatry/Physical Medicine
Cardio/Thoracic Surgery	General Surgery	Neurosurgery	Psychiatry
Chiropractic	Genitourinary	Occupational Medicine	Pulmonology
Gastroenterology	Hospitalist	Ophthalmology	Radiology
Ear/Nose/Throat (ENT)	Immunology	Oncology	Urology
Emergency/Critical Care	Infectious Disease	Other (Specify)	
Orthopedic Surgery - Spine	Orthopedic Surgery - Wrists	Orthopedic Surgery - Knees	
Orthopedic Surgery - Shoulders	Orthopedic Surgery - Hands	Orthopedic Surgery - Ankles	
Orthopedic Surgery - Elbows	Orthopedic Surgery - Hips	Orthopedic Surgery - Feet	

Conditions / Disorders Of (by body system) - Choose all that apply

Cardiovascular	Immune/Lymphatic	Nervous	Skin
Circulatory/Vascular	Maxillofacial	Renal	Urinary
Digestive/Excretory	Mental/Behavioral Health	Reproductive	All (Generalist)
Endocrine/Exocrine	Musculoskeletal	Respiratory	
Infections		Other (Specify)	

Body Parts Treated - Choose all that apply

Arteries/Veins/Blood	Hand	Trunk/Ribs	Genitourinary Genitalia, Kidneys, Urinary
Brain - Mental/Behavioral	Arm (unspecified)	Abdomen Gastrointestinal Tract, Liver	Reproductive System
Brain - Physical/Neurological	Cervical Spine		Knee
Ears	Thoracic Spine	Organs/Glands Pancreas, Spleen, Appendix	Ankle
Eyes	Lumbar Spine	Skin	Foot
Face/Nose/Mouth Throat/Scalp	Pelvis/Hips/Sacrum	Skull	Leg (unspecified)
Shoulder	Lungs/Respiratory System	Nerves	All (Generalist)
Elbow	Heart	Other (Specify)	
Wrist			

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Primary Location

Legal Name of Practice:		DBA Name:
Address 1:		Phone Nbr:
City:		Fax Nbr:
State:	Zip:	County:

Additional Locations

Legal Name of Practice:		DBA Name:
Address 1:		Phone Nbr:
City:		Fax Nbr:
State:	Zip:	County:

Legal Name of Practice:		DBA Name:
Address 1:		Phone Nbr:
City:		Fax Nbr:
State:	Zip:	County:

Legal Name of Practice:		DBA Name:
Address 1:		Phone Nbr:
City:		Fax Nbr:
State:	Zip:	County:

Legal Name of Practice:		DBA Name:
Address 1:		Phone Nbr:
City:		Fax Nbr:
State:	Zip:	County:

Legal Name of Practice:		DBA Name:
Address 1:		Phone Nbr:
City:		Fax Nbr:
State:	Zip:	County:

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Physician/Chiropractor Name:

Date:

Check Yes or No.

For any yes responses to questions 2 - 8, relevant supporting documents must be submitted with your application.

1. Have you ever been licensed in a state other than Nevada? If yes, please provide state(s) and dates below.

YES NO

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2. Has your license to practice medicine/chiropractic in any jurisdiction ever been denied, revoked, voluntarily or involuntarily terminated, relinquished, suspended, otherwise limited or restricted or been made subject to a program of probation, or have you ever been issued a citation or letter of reprimand by the licensing agency, or have formal or informal proceedings, or investigations, toward any of those ends ever been commenced?

YES NO

3. Has disciplinary action ever been filed against you by any workers' compensation authority, Medicare or Medicaid (CMS), medical facility, health maintenance organization, or professional practice board/society/association for fraud, medical billing fraud, substance abuse, prescribing controlled substances or quality of patient care?

YES NO

4. Have you ever been sanctioned for unprofessional conduct or discriminatory treatment in the care and/or treatment of patients in any state?

YES NO

5. Has your Drug Enforcement Agency or other controlled substances authorization ever been denied, revoked, voluntarily or involuntarily terminated, suspended, or restricted or have formal or informal proceedings, or investigations toward any of those ends ever been commenced?

YES NO

6. Have you ever been convicted of a criminal offense other than a minor traffic violation?

YES NO

7. Has the State of Nevada, Division of Industrial Relations ever issued a warning to you or imposed an administrative fine on you?

YES NO

8. Have you ever been suspended or removed from the State of Nevada Division of Industrial Relations Panel of Treating Physicians and Chiropractors or any other provider list as a disciplinary measure in Nevada or another state?

YES NO

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Physician/Chiropractor Name:

Date:

Please read and check each box indicating your understanding and agreement with each statement.

The information provided is both complete and accurate to the best of my knowledge. I understand that providing inaccurate information or documentation may result in the denial of this application. Incomplete applications will not be processed.

I agree to comply with Nevada's standards of care and use the ACOEM Guidelines adopted by the State of Nevada, Division of Industrial Relations pursuant to NRS 616C.250 and NAC 616C.123.

I agree to comply with the provisions of Chapters 616A through 617, inclusive, of the NRS and NAC. Failure to do so may result in disciplinary action including suspension or removal from the Treating Panel of Physicians and Chiropractors (NAC 616C.006).

I agree to notify the State of Nevada, Division of Industrial Relations (DIR) Workers' Compensation Section Medical Unit in writing of any changes to any of the information provided in this application packet including, but not limited to, legal name of practice, office address, specialty, licensing board status, email address, telephone number, and willingness/ability to treat Nevada's injured employees **within 14 calendar days of the change(s)**.

I agree to comply with the billing practices and reimbursement described in the NRS and NAC and the Nevada Medical Fee Schedule for Workers' Compensation (available at <http://dir.nv.gov/WCS/home/>), which is updated annually.

I attest that I have read, and understood this completed application. I also understand and agree that my electronic signature below has the full force of the law of an original signature.

Physician / Chiropractor Signature

Date

Designated Contact

Designated Contact Email

By submitting this application, the physician acknowledges that the designated contact person is authorized to receive communications from the WCS Medical Unit pertaining to the application.

Save the completed application as a new file, and email it as an attachment to medpanelapps@dir.nv.gov.

For any questions or concerns regarding the application, contact the Medical Unit at medpanelapps@dir.nv.gov.